FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION 03/30/2011 B. WING 445380 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5798 HIXSON HOME PLACE HIXSON, TN 37343 LIFE CARE CENTER OF HIXSON COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF This Plan of Correction is the F 156 RIGHTS, RULES, SERVICES, CHARGES facility's credible allegation of SS=E compliance. Preparation and/or The facility must inform the resident both orally and in writing in a language that the resident execution of this plan of understands of his or her rights and all rules and correction does not constitute regulations governing resident conduct and admission or agreement by the responsibilities during the stay in the facility. The provider of the truth of the facts facility must also provide the resident with the alleged or conclusions set forth in notice (if any) of the State developed under the statement of deficiencies. The §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the plan of correction is prepared resident's stay. Receipt of such information, and and/or executed solely because the any amendments to it, must be acknowledged in provisions of federal and state law writing. require it. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Any deficiency statement ending with an asterism (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days the safeguards provide sufficient protection to the patients. following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued If continuation sheet Page 1 of program participation.

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Event ID: 479Y11

Facility ID: TN3305

(X6) DATE

TITLE

OF HEALTH AND HUMAN SERVICES

PREFIX

TAG

PRINTED. VHIONES FORM APPROVED MB NO. 0938-0391

03/30/2011

(X5).

DATE

DEPARTMENT OF HEALT	H AND HUMAN SERVICES	*		OMB NO. 0938
CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445380	B. WING		03/30/201
NAME OF PROVIDER OR SUPPLIES LIFE CARE CENTER OF HIX		57	ET ADDRESS, CITY, STATE, ZIP C 98 HIXSON HOME PLACE XSON, TN 37343	
	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	E APPROPRIATE

TAG

F 156

Continued From page 1 F 156 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and

Corrective Action:

F 156

Facility staff have a meeting set up with the Resident Council for 4/19/11 to discuss Resident Council concerns regarding choices significant to the residents, visitation access to family members, personal items in the rooms and meal time services.

DEFICIENCY)

Facility Administration will conduct a family meeting on 4/26/11 to discuss any family concerns.

Potential:

Residents in the facility have the potential to be affected. Family members of residents in the facility have the potential to be affected.

Measures:

Administrative Staff will send a letter to family members to inform them of facility visitation process by 4/27/11.

Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11.

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Event ID: 479Y11

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PRINTED: U4/UDIZUTT FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

445380

B. WING

03/30/2011

STREET ADDRESS, CITY, STATE, ZIP CODE 5798 HIXSON HOME PLACE

		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
AME OF PE	ROVIDER OR SUPPLIER		5798 HIXSON HOME PLACE	
CAE	RE CENTER OF HIXSON		HIXSON, TN 37343	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
		F 150	S — — cots with	
E 156	Continued From page 2	Fin		
, ,,,,,	applicable State law.		· 1 to /formilies in a // Hour care Proces	
	Asset Of	<u> </u>	meeting to discuss and address concerns	
	The facility must inform each resident of the		and resident status.	1.
	I a proceed and way of contacting the		vooident	
	physician responsible for his or her care.		Activities staff reports any resident	
	1.7		brought forth in the resident	
	The facility must prominently display in the facility		council meetings to the appropriate	
	the information and bloying to region in	10 14	department for follow-up.	
	liangle for admission of a and william		Activities Staff and Social Services Staff	
	the street about how to apply to and use		will conduct random weekly resident	
			interviews to ask about any concerns	
	receive refunds for previous payments covered any		related to visitation hours, private	
	such benefits.		telephone access, dising service and	
	\$ 100 miles 100		personal items allowed in resident	
	This REQUIREMENT is not met as evidenced		personal fields die	N
	This REQUIREMENT IS NOT THE AS STABLES		rooms.	1
	by: Based on observation, resident/family/group		Monitor:	1
			Any concerns brought up by resident or	10.00
22	facility failed to communicate at admission and		family during the 72 hour care plan	•
		į.	are addressed will the	1
			appropriate staff or department and	
			changes to the resident's plan of care or	
		İ	staff in-service or education is conducted	
		1	on an as needed basis.	
	allowed in residents from the group interview.		Activities staff reports any concerns	1 :
	alert, onome	1	relayed during the resident council	
	The findings included:		La the Derformance	
	The many		Improvement Committee in the monthly	
			performance improvement meeting.	
	the facility on		1 -	
	Observation on the front door of the facility on		Activities and Social Services staff will	
929	Observation on the front door of the March 29, 2011, at 7:30 a.m., revealed signage March 29, 2011, at 7:30 a.m., were between 8:00		report the results of the resident	
			l Dertormance	
			Committee in the monthly	4-27-2
	roverled the front door was looked.		Desformance Improvement Meeting 10	
	access from the outside.	1	describe to ensure compliance.	
	**************************************		Facility ID: TN3305 If continuation s	neet Page 3

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Event ID: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SUF	ED
AND PLAN OF	F CORRECTION .	445380	A. BUI		•	03/30	/2011
	ROVIDER OR SUPPLIER	. 1	<u> </u>	5	EET ADDRESS, CITY, STATE, ZIP CODE 798 HIXSON HOME PLACE IXSON, TN 37343	* 8 * *	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRÉF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JULU BE 1.	(X5) COMPLETION DATE
F 156	Family interview of a.m., in a resident hours are 8:00 a.m. side doors remain preventing family rand family member prior to 8:00 a.m. answered the buzz door entrance). Or revealed if the famentrance into the could not get dres room. Group interview of in the Activity Roor entrance into the could not get dres room. Group interview of in the Activity Roor esidents revealed were unable to error Review of facility (admissions inforfamilies) revealed to reside the ability to gain hour visitation (8). Interview with the 2011, at 2:00 p.m. revealed family mentry into the building and side of the ability revealed family mentry into the building and side of the ability revealed family mentry into the building and side of the ability into the	n March 29, 2011, at 10:30 is room, revealed facility visiting in to 8:00 p.m.; the front and locked until 8:00 a.m., members access to residents, ers' entrance into the building was dependent upon who zer (attached at the outside continued family interview nily member was unable to gain facility by 7:30 a.m., the resident sed in time to eat in the dining on March 29, 2011, at 2:00 p.m., or with twelve alert, oriented at the resident's family members after the facility prior to 8:00 a.m. provided documents mation provided to residents and in o written information was ents regarding visitation hours or access into the facility for off		156			
	Resident group i	nterview on March 29, 2011, at Activity Room, revealed group (who did not have a one in their room), were unaware		**	Escritiv ID: TN3305	continuation she	eet Page 4 of 3

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Event ID: 479Y11

PRINTED: U4/U3/ZVT FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLÍA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 03/30/2011 B. WING 445380 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5798 HIXSON HOME PLACE HIXSON, TN 37343 LIFE CARE CENTER OF HIXSON (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DEFICIENCY) TAG F 156 Continued From page 4 F 156 of a phone available for private use. Resident #1 stated (in the group interview) residents had use of a cordless phone at the previous facility (from which the resident moved to the current facility), but cordless phones were not currently available at this facility for resident use. Interview with the Administrator on March 30, 2011, at 2:05 p.m., in the Conference Room, revealed there was a cordless phone for use at the nurse's station. Review of admission materials revealed no information was provided to residents at the time of admission or thereafter regarding the availability of use of a cordless phone at the nurse's station for private telephone calls. Interview with the Administrator on March 30, 2011, at 2:15 p.m., in the Conference Room, revealed the Administrator depended on the Resident Council President to share with other residents information about the facility, and confirmed residents had not been informed of their right to make private telephone calls through the use of a cordless phone at the nurse's station. Resident group interview on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Room, revealed the residents concern regarding personal items, such as picture frames, in the

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room. Continued group interview revealed residents were asked to take pictures out of picture frames and place the pictures on a small

Review of admission materials revealed no

bulletin board in the resident's rooms.

written information provided to residents about Event ID: 479Y11

Facility ID; TN3305

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DEPART	MEMICITIE	A MEDICAID CEDVICES			OND ITO.	
CENTER	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
STATEMENT	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A BUILDING			
MD Davis		NAME - 10.5 SAME	B. WING		03/30	/2011
		445380		TATE 719 COD		
	ROVIDER OR SUPPLIER	PON	57	ET ADDRESS, CITY, STATE, ZIP COD 98 HIXSON HOME PLACE XSON, TN 37343		
LIFE CAP	RE CENTER OF HIXS			DECLARERS PLAN OF CORE	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	TARL OFFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOOLD RE	COMPLETION DATE
	Continued From p	age 5	F 156		* 76	
F 156	what personal iten allowed in the root	ns were allowed and not	3			
	Interview with the 2011, at 2:27 p.m.	Administrator on March 30, , in the Conference Room, ts had not been provided n about the specific items				
		* ;			020	
	at 4:35 p.m., in the room) revealed the resident to go (to	sident #17 on March 28, 2011, e day room (next to the dining e licensed nurse asked the the resident's room) for a nued observation revealed the		•		
is a	resident became room as (the resi room to open for observation revea	dent) was waiting for the dining dinner service. Continued aled the resident verbalized (the aid the dining room would be dent) did not get back to the	·		·.·	
	from 2:00 p.m. ul Room, revealed breakfast in the dining room after	nterview on March 29, 2011, ntil 3:00 p.m., in the Activity residents were not allowed to eat dining room if they arrived at the 8:30 a.m. Continued group of if the residents did not eat in they could not order food items te menu.				
	(CDM) on March Conference Roo the dining room	e Certified Dietary Manager 30, 2011, at 2:45 p.m., in the m, revealed if residents arrived a late (after the breakfast had beer ident's tray was sent to the floor, ould have to bring the tray back to	0		If continuation sh	eef Page 6 of 3
1	100	T		Encillo ID: TN3305	it continuation so	Opr. 1 496 0 51.

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Event ID: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION		E CONSTRUCTION	(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLE	
	40	445380	B, WIN)/2011
	ROVIDER OR SUPPLIER			579	ET ADDRESS, CITY, STATE, ZIP CODE 98 HIXSON HOME PLACE	ŕ	
LIFE CAR	RE CENTER OF HIX	SON		HD	XSON, TN 37343	ECTION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 156	the dining room. CDM confirmed n	rage 6 Continued interview with the ownitten information regarding the sand a la carte services was sidents at admission, or	F	156		9 mg	
F 166 \$S=E	483.10(f)(2) RIGH	TTO PROMPT EFFORTS TO /ANCES	F	166	m166	Ñ z	
	facility to resolve have, including the of other residents. This REQUIREM by: Based on a reviewinutes and interpretations.	ENT is not met as evidenced w of resident council meeting triew, the facility failed to resolve hts about bedtime snacks and fee prior to breakfast.			F 166 Corrective Action: Facility representatives will me the Resident Council on 4/19/discuss bedtime snacks and avoif coffee prior to breakfast. Potential: Residents in the facility have potential to be affected. Measures:	ailability	
	Review of reside minutes from Se revealed at the meeting, resident receiving bedtim Group interview residents on Ma 3:00 p.m., in the residents voiced not consistently Interview with the (SDC) on March	nt council monthly meeting ptember 2010 until March 2011, January 2011 resident council its complained about not	1	2	Resident bedtime snacks are the dietary department daily a delivered to the nurses' statio include the diabetic, nutrition snacks and house snacks. Die has nurse initial label that snareceived. The signed label is to dietary and reviewed by the Dietary Manager on a random nurse then instructs the certificassistants to pass the bedtime implemented 4/14/11.	and ns to nal need stary staff acks were then taken the Certified m basis. The	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING			
		445380	B. WING		03/30/2011	
	ROVIDER OR SUPPLIER	SON	57	EET ADDRESS, CITY, STATE, ZIP CODE 198 HIXSON HOME PLACE IXSON, TN 37343		
(X4) ID PREFIX TAG	ACACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	אנ
F 166	snacks at bedtime SDC revealed tho specific nutritional and the Registere speak with the resident's mer Interview with the Administrator on the conference rowere to be offered no specific nutrition with the RD before snack, and the resident's snacks in the specific snacks in	vided individually prepared Continued interview with the se residents (who had no needs) could request a snack, d Dietitian (RD) would need to ident to "work the snack into	F 166	The dietary staff provides coffee of the nursing staff to offer to residents beginning 4/14/11. Nursing staff was in-serviced regard providing residents with bedtime so by the Director of Nursing on 4/4/11. Nursing Staff was in-serviced on 4 and 4/13/11 by the Director of Nursing on 4/4/11. Nursing Staff was in-serviced on 4 and 4/13/11 by the Director of Nursing staff will be in-serviced availability of coffee prior to break Nursing staff will be in-serviced at education will be provided in new orientation. Nursing staff will be serviced on or before 4-27-2011. associates will not be scheduled to the floor after 4-27-2011 until in-sit completed.	rding nacks 11. /12/11 rsing cs and cfast. nd hire in- The	
	minutes from Seprevealed at the Omeeting, resident council resident council revealed docume to the residents: a.m., no service at Resident group in 2:00 p.m., in the residents had be to be opened, will yet occurred. Council the morning until the morning until	at council monthly meeting stember 2010 until March 2011, ctober 2010 resident council is complained about the lack of to a.m. Continued review of minutes for December 2010, intation of feedback from Dietary "Dining service starts at 7:30 available prior to that" Interview on March 29, 2011, at Activity Room, revealed en told the Ice Cream Parlor was the coffee service, but this had not ontinued group interview revealed were unable to obtain coffee in their breakfast tray was served.		Monitor: Activities staff and Social Service will conduct random weekly resinterviews to ask about availability bedtime snacks and coffee. Activities Director or Social Services Director report results of resident interview Performance Improvement Commonthly in the Performance Improvement meeting for three rensure compliance.	dent ty of vities ctor will ws to the mittee dent 4-27-20	111

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		& MEDICAID SERVICES	(X3) M	I II TIPI	E CONSTRUCTION	(X3) DATE SU	IRVEY
TATEMENT IND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING		COMPLE	TED
		445380	B. WII			03/3	0/2011
	ROVIDER OR SUPPLIER	· ·		579	ET ADDRESS, CITY, STATE, ZIP CODE 18 HIXSON HOME PLACE		V 8 88
LIFE CAF	RE CENTER OF HIXS			HD	(SON, TN 37343 PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DESIGNO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	XI	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION
E 400	O Frank From N	200 8	F	166			
F 166	the Conference Ro concern about cof	age of factors and are a second are a second and a second are a second	•		el .	,	
F 172 \$S=E	PROVISION OF V	i i	F	172		Í	
	The resident has t provide immediate following:	he right and the facility must access to any resident by the				3 8 (20)	* 6.5
·	Any representative	e of the Secretary;			F 172		
	Any representative	e of the State;					
	The resident's ind	ividual physician;			Corrective Action:		,
	(established unde Older Americans	nsible for the protection and			Facility staff have a meeting set the Resident Council for 4/19/11 discuss Resident Council concer regarding choices significant to residents, visitation access to far	to ns the mily	
	advocacy system	for developmentally disabled lished under part C of the isabilities Assistance and Bill of			members, personal items in the and meal time services.		
	Rights Act); The agency respond	onsible for the protection and for mentally ill individuals			Facility Administration will con family meeting on 4/26/11 to di family concerns including access facility and visitation hours.	scuss any	
	(established under for Mentally III Ind	er the Protection and Advocacy lividuals Act);			Potential:		
P	relatives of the re				Residents in the facility have the potential to be affected. Family members of residents in	the	1. 1.22
	regident's right to	nable restrictions and the deny or withdraw consent at any are visiting with the consent of			facility have the potential to be	affected.	<u></u>

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CENTERS FOR MEDICARE & MEDICAL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL	LTIPLE CONSTRUCTION DING	(X3) DATE \$	
¥		445380	B. WING			30/2011
	ROVIDER OR SUPPLIER	ON	5	STREET ADDRESS, CITY, STATE, ZIP CO 5798 HIXSON HOME PLACE HIXSON, TN 37343		
(X4) ID PREFIX TAG	VENCH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 172	any resident by an provides health, so the resident, subject or withdraw consections. This REQUIREMED by: Based on observation of the findings included to ensure reaccess to visitation. The findings included the finding stating facility visitation, and 8:00 p.m. revealed the front entrance from the Family interview of a.m., in a resident hours are 8:00 a. side doors remain preventing family and the family me building prior to 8 someone answer outside entrance. Group interview of the Activity Romanda of the revealed to the source of the source	rovide reasonable access to y entity or individual that potal, legal, or other services to ect to the resident's right to deny int at any time. ENT is not met as evidenced tion, family/group interview, and provided documents, the facility sidents were granted free in by family. ded: e front door of the facility on at 7:30 a.m., revealed signage tation hours were between 8:00 in Continued observation door was locked preventing outside. on March 29, 2011, at 10:30 if's room; revealed facility visiting in locked until 8:00 a.m., members access to residents; embers' entrance into the :00 a.m. was dependent upon ing the buzzer (located on the	F1	Administrative Staff will se family members to inform the facility visitation process by Resident/family information addresses visitation hours, and telephone access, dining set personal items allowed in rewill be included in every nepacket and discussed by the Coordinator with the residentially beginning 4/27/11. The Interdisciplinary Team residents/families in a 72 him meeting to discuss and addresident status. Activities staff reports any concerns brought forth in the council meetings to the appropriate of the process of the product random week interviews to ask about any related to visitation hours, telephone access, dining sepersonal items allowed in trooms.	hem of y 4/27/11. In letter that private rvice and esident rooms admission admissions at and/or meets with our care plan ress concerns resident he resident propriate Services Staff ly resident y concerns private ervice and resident	of Prog. 10 of
i	·!			C-+891 IO: TM3305	If continuation she	et rage 10 of.

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Event ID: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES		A ZIDI E CONSTDUCTION	(X3) DATE SI	JRVEY
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION	COMPLE	TED
ND PLAN OF CORRECTION	IDENTIFICATION TO THE PARTY OF	A. BUIL		-	
	445380	B. WIN			0/2011
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2/P 5798 HIXSON HOME PLACE	CODE	¥ .
LIFE CARE CENTER OF HIX	Ю́И		HIXSON, TN 37343		(VE)
The second secon	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREFI TAG		THE APPROPRIATE	COMPLETION DATE
			Any concerns brought up family during the 72 hour meeting are addressed wit appropriate staff or depart changes to the resident's p staff in-service or education an as needed basis. Activities staff reports any relayed during the resident meeting to the Performant Improvement Committee performance improvement Activities and Social Service or the results of the reinterviews to the Perform Improvement Committee Performance Improvement three months to ensure continued the performance of the performance o	care plan h the ment and lan of care or on is conducted y concerns at council ce in the monthly at meeting. vices staff will esident ance in the monthly ont Meeting for	4-27-201
	. 3 3			<u> </u>	
FORM CMS-2567(02-99) Previous Ver	sions Obsolete Event ID: 4	179Y11	Facility ID: TN3305	If continuation she	e 1014

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

TATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION .	(X3) DATE SURVE COMPLETED	
		445380	B. Win			03/30/20	011
	ROVIDER OR SUPPLIER	ON		57	EET ADDRESS, CITY, STATE, ZIP CODE 1988 HIXSON HOME PLACE		
LIFE CAP	RE CENTER OF HIXS			H	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX TAG	VEYOU DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE CC	(X5) MPLETION DATE
F 172	Continued From pa	age 10	F	172			
	(admissions inform	rovided documents nation provided to residents and Idress visitation hours					
F 174	2011, at 2:00 a.m., revealed family me entery the building 483.10(k) RIGHT	Administrator on March 30, in the Conference Room, embers were to be allowed if they used the buzzer. TO TELEPHONE ACCESS	F	174			
. 55-0	The resident has t	he right to have reasonable of a telephone where calls can eing overheard.			F 174 Corrective Action:		3 Dax 61 2 3
ū	by: Based on group/re facility admission i ensure one (#1) of	esident interview and a review of materials, the facility failed to f seventeen residents reviewed, is without a personal phone, elephone for private use.			Director of Nursing met with Re #1 on 4/14/11 to discuss resider to cordless phone for private pe phone calls. Facility staff have a meeting set the Resident Council for 4/19/1 discuss Resident Council concergarding choices significant to residents, visitation access to fa	t up with t to tres	
	2:00 p.m., in the A residents in the graph of a phone availate stated (in the ground of a cordless phone which the resident but cordless phone for use at this factorial in the factorial states.	terview on March 29, 2011, at activity Room, revealed roup (who did not have a se in their room), were unaware ple for private use. Resident #1 up interview) residents had use the previous facility (from a troved to the current facility), les were not currently available dity. Administrator on March 30,			members, personal items in the and meal time services. Potential: Residents in the facility have the potential to be affected.		

FORM CMS-2567(02-99) Previous Versions Obsoleta

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet Page 11 of 3

PRINTED: 04/05/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CUA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION B. WING 03/30/2011 445380 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5798 HIXSON HOME PLACE HIXSON, TN 37343 LIFE CARE CENTER OF HIXSON PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FUU. PREFIX DATE (X4) ID CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG Measures:

> Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11. Copy of this letter will be provided to current residents prior to 4/27/11.

Activities staff reports any resident concerns brought forth in the resident council meetings to the appropriate department for follow-up.

Activities Staff and Social Services Staff will conduct random weekly resident interviews to ask about any concerns related to visitation hours, private telephone access, dining service and personal items allowed in resident rooms.

Monitor:

Activities staff reports any concerns relayed during the resident council. meeting to the Performance Improvement Committee in the monthly performance improvement meeting.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation shee II A

PRINTED: U4/00/2011 FORM APPROVED OMB NO. 0938-0391

DELAKT	O FOR MEDICARE	& MEDICAID SERVICES		10		DATE CHO	
TATEMENT	OF DEFICIENCIES	TO PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION (X3)	DATE SUR' COMPLETE	.D
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING			
		445380	B. WII	NG		03/30/	2011
NAME OF P	ROVIDER OR SUPPLIER		1	57	EET ADDRESS, CITY, STATE, ZIP CODE 98 HIXSON HOME PLACE		
LIFE CAF	RE CENTER OF HIXS	SON		HI	XSON, TN 37343		- NE
(X4) ID PREFIX TAG	- ALL DESIGNENT	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE I	(X5) COMPLETION DATE
F 174	2011, at 2:05 p.m. revealed there wa the nurse's station Review of admiss information was p of admission or the availability of use nurse's station for Interview with the 2011, at 2:15 p.m. revealed the Admission of Council	in the Conference Room, s a cordless phone for use at in ion materials revealed no rovided to residents at the time ereafter regarding the of a cordless phone at the private telephone calls. Administrator on March 30, in the Conference Room, inistrator depended on the President to share with	F		Activities and Social Services staff will report the results of the resident interviews to the Performance Improvement Committee in the month Performance Improvement Meeting fo three months to ensure compliance.	aly or	4-27-2011
F 221 SS=D	residents information confirmed resident their right to make the use of a cord 483.13(a) RIGHT	tion about the facility, and hts had not been informed of e private telephone calls through less phone at the nurse's station. TO BE FREE FROM		221	F 221		
	The resident has physical restraint discipline or converge the resident. This REQUIREM by: Based on medical interview, the fact (#4) for the use of residents review. The findings income.	cluded:			#1) The Initial Restraint Assessment for resident #4 for blanket roll for scoop (bolster) mattress was completed by the Interdisciplinary Team on 4-13 Potential to be Affected: #2) Residents with blanket roll bolster side mattresses have the potential to be affected.) e 3-11.	
	Resident #4 was	s admitted to the facility on			If configure	ation sheet	Page 12 0
	EST.			-	acility ID: TN3305 If continua	ation sneer	rage it

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Event 1D: 479Y11

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TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A.	445380	B. WING	<u> </u>	03/30/2011
	ROVIDER OR SUPPLIER		579	ET ADDRESS, CITY, STATE, ZIP CODE 88 HIXSON HOME PLACE (SON, TN 37343	e
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER OF CORRECT PR	OUTD BE COMPTELLOW
TAG	REGULATORY.OR	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
F 221	Continued From p	age 12	F 221	Measures:	
	February 17, 2011 Fracture Femur, C Osteoporosis, and	, with diagnoses including erebral Vascular Accident, Mental Disorder.	8 .	#3) Initial restraint assessm will be completed upon init of a restrictive device, then	tiation
	revealed the resid- risk for falls and or implemented a lov	niew of the Interim Care Plan ent had a history of falls, was at a March 17, 2011, the facility bed with a pressure sensitive Continued review revealed the ed a scoop mattress and fall		updated/reviewed quarterly with a significant change st according to the Minimum Set schedule.	atus
	mats on February	27, 2011, and on March 14, d a blanket roll to the edges of s until foam rolls (bolsters) were		Director of Nursing or Assi Director of Nursing will pe monthly audits to check completion of restraint assessments.	istant erform
	Observation on M revealed the resident law here so	view revealed no assessment of estraint. arch 30, 2011, at 10:45 a.m., lent in bed with a pressure oop mattress with bolsters to on the floor at bedside.		The Interdisciplinary Team in-serviced by Nursing Administration on 4/13/11 process of completing rest assessments.	on
F 226 SS=0	Interview with the Corporate Nurse p.m., in the confe bolsters did restrinad not been ass 483.13(c) DEVEL ABUSE/NEGLECTHe facility must policies and productive atments as a second productive atments as a second policies and productive atments as a second productive atments as a second policies and policies and productive atments as a second policies and productive atments as a second policies and polic	Director of Nursing and the on March 30, 2011, at 1:30 rence room, confirmed the ct the residents movement and essed as a restraint.	F 226	#4) Monthly audits for completion of resident res assessments will be condu Director of Nursing or Ast Director of Nursing and reported to the Performan Improvement Committee months for compliance.	sistant esults

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		LE CONSTRUCTION	COMPLETED
		445380	B. Wil			03/30/2011
	ROVIDER OR SUPPLIER	SON		57	EET ADDRESS, CITY, STATE, ZIP CODE 198 HIXSON HOME PLACE IXSON, TN 37343	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLETIC
F 226	Continued From pa	age 13	F	226	F 226 Corrective Action:	
	by: Based on Interview documents and fa failed to correctly i		i,		Facility unable to complete correaction for resident #13, she was discharged to home prior to the a survey. Facility unable to complete correaction for residents # 9 and #14 the time lapse from the report or concern and comment to survey.	ective due to 1 the
	on February 25, 2 allegation of abuse (Certified Nursing provided documer Investigation and to investigate and (Registered Nurse contact with conce	provided documents revealed 011, resident #9 reported an e of resident #14 by CNA: Assistant) #1. Review of facility hts revealed "Facility ResponsePerson designated follow-up with Concern e #1)Date/Time of initial arned party2/25/2011-1100 estigation FindingsNo abuse	ē.	**	Certified Nursing Assistant #1 wassigned on 2/25/11. Certified N Assistant was in-serviced on 3/3 the Staff Development Coordina Resident rights and resident abu Potential: Residents in the facility have the potential to be affected.	lursing 0/11 by ator on se.
	discovered at this (resident #9 and # assignment sheet on-going monitoring written statement of the control of	timeBuddy System on (14) in place per staffing Follow-up to continue c (with) ng per charge nurses." provided documents revealed ent was obtained from CNA #1, ing with CNA #1, or other			Measures: The Staff Development Coording began in-service education for strengarding Resident Rights and I abuse on 3/30/11. The Director of Nursing condustryice education on 4/4/11 for regarding resident abuse and/or	staff Resident cted in- all staff
	on February 28, 2 concerns about p	provided documents revealed 2011, resident # 13 reported ain management, and concerns sessment of the resident's a swollen leg. Continued review			investigation, abuse regulations definitions, reporting alleged at witness interview policy. Reviconcern and comment form and complete.	buse, ew of

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Event ID: 479Y11 .

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TATEMENT	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		445380	B. Wit	- /a/a			0/2011
	ROVIDER OR SUPPLIER	76		5798	ET ADDRESS, CITY, STATE, ZIP CO 8 HIXSON HOME PLACE (SON, TN 37343		<u> </u>
(X4) ID PREFIX TAG	VEACH OFFICIENT	TAYEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	of facility provided was assigned to in Review of "Facility dated March 1, 20 FindingsReside charge nurse to go and agrees to prooften and consist facility provided during the strength of	documents revealed RN #1 Investigate the allegations. Investigation and Response", Investigated until March and Investigated and resident and and Investigated and shall remain and and investigate the occurrence. In the administrator will appoint to investigate the occurrence. In the representative will review and responsible parties have the circumstance5. The all include a written summary the staff members on all shifts with the resident at the time of the review with other residents who	F	226	The Director of Nursing conservice education on 4/13/1 department managers on ab investigation and witness in policy. The Director of Nursing conservice education with staff regarding abuse and neglect Associates will be in-service education will be provided orientation. Associates will serviced on or before 4-27-associates will not be scheduled the floor after 4-27-2011 units completed. Concern and Comment former viewed for completion in Head Morning Meeting and maintained by the Social Scholer which will included documentation of investigation. Monitor: The Social Services Direct the Concern and Comment completion of investigation up in the Monthly Perform Improvement Meeting more	I with buse/neglect aterview Inducted infon 4/13/11 it. I wed and in new hire libe infollowing to be a long will be ervices it ion following the form and following the mand following the property of the mand following th	4-27-201
•	received care or perpetratorA re surrounding the	services from the alleged eview of all circumstances incident."		<i>a</i>	months to ensure complian	*.	
	Interview with th	e Administrator and Director of th 30, 2011, at 9:00 a.m., in the					<u> </u>

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES	TAN MILLET	PLE CONSTRUCTION	(X3) DATE S	JRVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	G	- COMPLE	TED
	445380				0/2011
NAME OF PROVIDER OR SUPPLIER	SON	5	REET ADDRESS, CITY, STATE, ZIP 1798 HIXSON HOME PLACE HIXSON, TN 37343	CODE	· · · · · · · · · · · · · · · · · · ·
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
2011, allegation of the February 28, 2 treatment was not 2011; and the facil allegations of abus	age 15 , confirmed the February 25, abuse was not investigated; 011, allegation of lack of investigated until March 30, ity policy on investigating se and neglect was not correctly ETERMINATION - RIGHT TO	F 226			
schedules, and he her interests, asses interact with memlinside and outside about aspects of hare significant to the significant to the significant to the second on observation for twelve of twelve provide choices shareas of visitation personal items in services. One (#1 reviewed express resident) would mand not be allowed time to eat. The findings inclusions and not the second of the secon	entron, resident/group interview residents, the facility failed to gnificant to the residents in the access to family members, the room and mealtime (17) of seventeen residents ed concern due to a fear (the liss a meal in the dining room d in the dining room at a later		F 242 Corrective Action: Facility staff have a meeting the Resident Council for a discuss Resident Council regarding choices significates residents, visitation access members, personal items and meal time services. Nursing spoke with reside on April 20, 2011, and reached has to leave the dinning period of time that he will return to the dinning room. Potential: Residents in the facility has potential to be affected.	4/19/11 to concerns ant to the s to family in the rooms ent number 17 assured him if g room for a l be able to a.	

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Event ID: 479Y11

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DELVILLE	S EOR MEDICARE	& MEDICAID SERVICES				(X3) DATE SU	RVEY
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		445380	B. Wit		·	03/30	/2011
NAME OF PR	ROVIDER OR SUPPLIER			579	ET ADDRESS, CITY, STATE, ZIP CODE 98 HIXSON HOME PLACE		
LIFE CAR	E CENTER OF HIXS	ON		HD	XSON, TN 37343	PAION	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE 1	COMPLETION DATE
F 242	outside. Family interview o a.m., in a residen	n March 29, 2011, at 10:30 t's room, revealed facility 8:00 a.m. to 8:00 p.m.; the front main locked from 8 p.m. until	F	242	Measures: Meeting with Resident Council on 4/19/11 with facility staff to concerns of significant choices residents, visitation access to face in the	o the mily	
	8:00 a.m., prevent visiting residents, entrance into the dependent upon so (located on the our response from instentry).	and the family members access to and the family members' puilding prior to 8:00 a.m. was someone answering the buzzer atside of the door requiring side to allow access to unlock for			members, personal fiems in the and mealtime services. Administrative Staff will send a family members to inform them facility visitation process by 4/2	letter to of 27/11.	·
	in the Activity Roc residents reveale were unable to er Review of facility	on March 29, 2011, at 2:00 p.m., om, with twelve alert, oriented of the resident's family members after the facility prior to 8:00 a.m. provided documents mation provided to residents and address visitation hours.			addresses visitation hours, privile telephone access, dining service personal items allowed in reside will be included in every new a packet and discussed by the Accoordinator with the resident a family beginning 4/27/11.	e and ent rooms admission lmissions and/or	£
	Interview with the 2011, at 2:00 p.n revealed family nenter the building	Administrator on March 30, n., in the Conference Room, nembers were to be allowed to g when they used the buzzer.		sis .	Activities Staff and Social Ser will conduct random weekly r interviews to ask about any co related to visitation hours, pri- telephone access, dining servi personal items allowed in resi	esidem incerns vate ce and	
	from 2:00 p.m. u Room, revealed regarding being such as picture group interview	nterview on March 29, 2011, ntil 3:00 p.m., in the Activity a concern residents had allowed to place personal items, frames, in the room. Continued revealed residents were asked to out of picture frames and place small bulletin board in the			rooms. Monitor: Activities and Social Services report the results of the reside interviews to the Performance Improvement Committee in the Performance Improvement Management	nt he monthly feeting for	4-27-201

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Event ID: 479Y11

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TATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		445380	B. Wit	√G		03/3	0/2011
	ROVIDER OR SUPPLIER	SON		57	EET ADDRESS, CITY, STATE, ZIP 198 HIXSON HOME PLACE IXSON, TN 37343	CODE	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 242	Review of admissi	on materials revealed no provided to residents about as were allowed and not	F	242	141		
590	2011, at 2:27 p.m.	Administrator on March 30, , in the Conference Room, ts had not been provided about the specific items dent's room.					130
	at 4:35 p.m., in the room) revealed the resident to go (to fingerstick. Contin- resident became to room as (the resident)	sident #17 on March 28, 2011, eday room (next to the dining elicensed nurse asked the the resident's room) for a nued observation revealed the upset about leaving the day dent) was waiting for the dining dinner service. Continued		a l			
3	observation the re	esident verbalized (the resident) ing room would be closed if (the get to the dining room at a				us us	
	from 2:00 p.m. un Room, revealed r breakfast in the d dining room after	terview on March 29, 2011, til 3:00 p.m., in the Activity esidents were not allowed to eat-ining room if they arrived at the 8:30 a.m. Continued group if the residents did not eat in they could not order food items e menu.		3.50			
	(CDM) on March	Certified Dietary Manager 30, 2011, at 2:45 p.m., in the n, revealed if residents arrived at ate (after the breakfast had been	:	<u> </u>			t Page 18 of 3

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Event ID: 479Y11

Facility ID; TN3305

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PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A45380 A BUILDING B. VINING STREET ADDRESS, CITY. STATE. ZIP CODE 5738 HIXSON HOME PLACE A BUILDING B. VINING STREET ADDRESS, CITY. STATE. ZIP CODE 5738 HIXSON HOME PLACE HIXSON HOME HIXSON HOME PLACE HIXSON HOME HIXSON HOME HIXSON HOME HIXSON HOME HIXSON HOME HIXSON HOME HIXSON HO	FOR MEDICA	DE & MEDICAID SERVICES			1	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HIXSON CAJD PARTIN TAG PARTIN TAG CAD DESCRIPTIVATION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG F 242 Continued From page 18 served), the resident's tray was sent to the floor, and someone would have to bring the tray back to the dining room. Continued interview with the CDM confirmed on written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter. F 250 SS=D The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hyperfension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was dated March 16, 2011, revealed the resident was dated for manual process. The stable practical physical process by the Executive Director on April 15, 2011. Health Information Management Director services and the services and the process by the Executive Director on April 15, 2011.		LY1) PROMDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HIXSON SUMMARY STATEMENT OF DEFICIENCIES FRECUED BY PILL FROM EACH CORRECTION EACH OF CROSS HIXSON HOME PLACE HIXSON, TO 37343 F242 Continued From page 18 served), the resident's tray was sent to the floor, and someone would have to bring the tray back to the dining room. Continued interview with the CDM confirmed no written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter. F 250 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was brieded promotion from the services and the resident was brieded process. The social services for one resident (#2) of seventeen resi	AND PLAN OF CORRECTION	OENTIFICATION NUMBER:	A. BUILDING			
STABLE OF PROVIDER OR SUPPLIES	·	445380			03/30	/2011
SAJ ID PREFIX TAGE SUMMARY STATEMENT OF DEFICIENCES IN PROPERTY AND TO CORRECTION ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 242 Continued From page 18 served), the resident's tray was sent to the floor, and someone would have to bring the tray back to the dining room. Continued interview with the CDM confirmed no written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter. F 250 SS=D The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was	NAME OF PROVIDER OR SUPPL	ER .	57	98 HIXSON HOME PLACE	×	9
PREFIX TAG SUMMARY STATEMENT OF DEPLEASE STULL REGULATORY OR IS CIDENTIFYING INFORMATION) PREFIX TAG	LIFE CARE CENTER OF H	IXSON	H			
F 242 Continued From Page 10 served), the resident's tray was sent to the floor, and someone would have to bring the tray back to the dining room. Continued interview with the CDM confirmed no written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter. F 250 SS=D The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was distributed to the resident service protector was inserviced on the POST form completion process by the Executive Director on April 15, 2011.	PREFIX (EACH DEFICI	NOV MIST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE 1	
This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was	served), the reand someone of the dining room CDM confirmed dining room seprovided to the thereafter. F 250 SS=D The facility muservices to attached to the confirment of th	sident's tray was sent to the floor, would have to bring the tray back to a. Continued interview with the in no written information regarding revices and a la carte services was residents at admission, or ROVISION OF MEDICALLY CIAL SERVICE st provide medically-related social in or maintain the highest residel, mental, and psychosocial		Corrective Action: The Physician Orders for Scop Treatment (POST) form for res was completed by the resident responsible party on April 14,	sident #2	
POST form and reports results to the Executive Director.	by: Based on med the facility fails social services residents revis The findings is Resident #2 v 16, 2011, with Vascular Acc	ical record review and interview, of to provide medically related for one resident (#2) of seventeen wed. Included: The admitted to the facility on March diagnoses including Cerebral dent, Hypertension, and Dysphagian of review of the Admission orders		Measure: Social Services Director will 100% audit of resident's POS completion by 4/18/11. The POST forms will be comduring the admission process The Social Services Director serviced on the POST form opposes by the Executive Director process by the Executive Director performs an audit of charts that include completic POST form and reports resu	complete a T forms for pleted was in- completion rector on ment of new admits on of the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet Page 19 of 3

PRINTED: U4/U5/ZU11 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			- COVETBUCTION	(X3) DATE SU	IRVEY
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLE	TED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUII				
		445380	B. WIN			03/3	0/2011
NAME OF PE	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	E CENTER OF HIXS	ON			IXSON, TN 37343		
LIFE OAK			ID	1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	CTION	(X5) COMPLETION
(X4) ID PREFIX TAG	THE PERIOD AND THE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
F 250	Continued From pa	age 19	F	250	Monitor:		
1 200	form).	-9-			Social Services Director will re	port	
1 0					- to the of new admit POST form	is in the	
	Medical record rev	riew of a Social Service note 011, revealed "Also reviewed			Derformance Improve	ment	
	DOOT form with (laughter) who stateswiii sign			Meeting monthly for three more compliance.	iuis to	4-27-2011
	it whencomes in	today in regards to (resident's)			ensure compitation.		4-21-2011
	wishes."		4				
	•8	3	×				
	Interview with the	Social Services Director on					
	March 30, 2011, a	tt 7:45 a.m., in the conference of follow up had been provided					
	husba Cacial Sen	ICE DIRECTOR MILL LITE LESIGETY					
	and or daughter to	determine code status.	-	279			
F 279	383 20(d) 483.20	(k)(1) DEVELOP		210			
SS≂D	19		13				
	A facility must use	the results of the assessment					
	to develop, review	and revise the residents					
	comprehensive p		-		F 279		
	The facility must	develop a comprehensive care					
	plan for each resi	dent mat includes measures			Corrective Action:		
	II -1 - Linning	and mental and psychosocial entified in the comprehensive			#1) Resident #4's comprehensi	ve care	
	needs that are id- assessment.	entined in the completioners			plan was updated 3-31-11 by F	Regional	
	(i) (i) (i) (ii) (ii) (ii) (ii) (ii) (i	h-t ara			Director of Clinical Services.		
	The care plan mi	ust describe the services that are a stain or maintain the resident's			Potential:		
1.	L'-back prooficat	de physical, mental, allu					
					#2) Residents with interim car have the potential to be affected	e pians ed.	İ
	A LAD DE and ON	CONTROL THAI WOULD OUT THE			nave the potential to be affect		
	be required unde	or \$483,25 but are not provided			1.60		
	8483.10 includir	ng the right to refuse treatment				52 31	
	under §483.10(b	0)(4).					
		*0					
		Svent ID: 479Y	11		Facility ID: TN3305	continuation she	et Page 20 of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 1D: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HIXSON SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MIXS THE PRECEDED BY FULL TABLE MIXSON HOME PLACE HIXSON, TN 37343 PROVIDER'S PLAN OF CONTENTION OR LOCAL DEFICIENCY MIXED THE PRECEDED BY FULL TABLE MIXSON, TN 37343 PROVIDER'S PLAN OF CONTENTION OR LOCAL DEFICIENCY MIXED THE PRECEDED BY FULL TABLE MIXSON, TN 37343 PROVIDER'S PLAN OF CONTENTION OR LOCAL DEFICIENCY MIXED THE PROPRIATE TABLE MIXED MIXED THE APPROPRIATE TABLE MIXED MIXED THE PRECEDED BY FULL TABLE MIXED MIXED THE PRECEDED BY FULL TABLE MIXED MIXED THE PRECEDED BY FULL TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE TABLE MIXED MIXED THE PROPRIATE T	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION	(X3) DATE SU	LED LEAEA
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HIXSON SUMMARY STATEMENT OF DEFICIENCIES (PACK) TO STORE HIXSON (N. 3743) TAG	AND PLAN O	F CORRECTION	and Capparan (Capparan) of Apparan	200		03/30	0/2011
F 279 Continued From page 20 This REGUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the care plan for one resident (#4) of seventeen residents reviewed. Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis, and Mental Disorder. Medical record review of the Interim Care Plan revealed the resident had a history of falls and was at risk for falls; March 17, 2011, the facility implemented low bed with a pressure sensitive alarm to the bed. Continued review revealed the facility implemented a scoop mattress and fall mats on February 27, 2011, and March 14, 2011, blanket roll to edge of scoop mattress until foam roll (bolsters) available. Medical record review of the care plan dated March 29, 2011, revealed the scoop mattress, floor mats, bolsters to bed were not addressed on the care plan. Medical record review of the care plan dated March 29, 2011, revealed the scoop mattress, floor mats, bolsters to bed were not addressed on the care plan was not updated to reflect the current interventions to prevent an injury from a fall. F 281 F 281 F 281 F 281 F 288 F 288 F 288 F 289 Continued From page 20 This REGUIREMENT is not met as evidenced by: CROSS-REFERNCE TO THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE Measures: Measures: ##3 Dipon completion of the completion of the care plan for falls, the care plan for falls, the care plan for falls, the care plan conditions to easure that the interventions are dated and carried over to the comprehensive care plan. Care plan coordinator will be in-serviced on 4/13/11 by Director of Nursing regarding comparison of interim care plan fall interventions are carried over to the comprehensive care plan. Director of Nursing will review Care Plan Comparison Form to Performance Improvement Committee monthly for three months for compliance.					5798 HIXSON HOME PLACE		
This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the care plan for one resident (#4) of seventeen residents reviewed. Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis, and Mental Disorder. Medical record review of the Interim Care Plan revealed the resident had a history of falls and was at risk for falls; March 17, 2011, the facility implemented low bed with a pressure sensitive alarm to the bed. Continued review revealed the facility implemented a scoop mattress and fall mats on February 27, 2011, and March 14, 2011, blanket roll to edge of scoop mattress until foam roll (bolsters) available. Medical record review of the care plan dated March 29, 2011, revealed the scoop mattress, floor mats, bolsters to bed were not addressed on the care plan. Interview with the Director of Nursing and the Corporate Nurse on March 30, 2011, at 1:30 p.m., in the conference room, confirmed the care plan was not updated to reflect the current interventions to prevent an injury from a fall. 483,00(k)(3)(i) SERVICES PROVIDED MEET Measures: #33) Upon completion of the comprehensive care plan for falls, the care plan coordinator will review the interim care plan coordinator will review the interventions are dated and carried over to the comprehensive care plan extracted and carried over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to the comprehensive care plan acarding over to Nursing will review Care Plan Comparison Form completed weekly by the Care plan acoord	PREFIX	VEACH DEFICIENCY	Y MIIST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
interventions to prevent an injury from a fail. F 281 483,20(k)(3)(i) SERVICES PROVIDED MEET F 281 4-27-20		This REQUIREME by: Based on medical the facility failed to resident (#4) of set Resident #4 was a February 17, 2011 Fracture Femur, C Osteoporosis, and Medical record rev revealed the reside was at risk for falls implemented low to alarm to the bed. (facility implemented mats on February blanket roll to edge roll (bolsters) avail Medical record rev March 29, 2011, re floor mats, bolster the care plan. Interview with the Corporate Nurse o p.m., in the confer- plan was not under	record review and interview, update the care plan for one venteen residents reviewed. dmitted to the facility on , with diagnoses including erebral Vascular Accident, Mental Disorder. diew of the Interim Care Plan ent had a history of falls and is March 17, 2011, the facility bed with a pressure sensitive Continued review revealed the end a scoop mattress and fall 27, 2011, and March 14, 2011, and of scoop mattress until foam lable. Ariew of the care plan dated evealed the scoop mattress, is to bed were not addressed on Director of Nursing and the on March 30, 2011, at 1:30 rence room, confirmed the care lated to reflect the current		Measures: #3) Upon completion comprehensive care plan coordinator interim care plan interim care plan interim care plan coordinator on 4/13/11 by Director regarding comparison plan fall intervention care plan. Director of Nursing Plan Comparison For weekly by the Care paudit that fall intervence over from the interim comprehensive care Monitor: #4) Director of Nursing of Plan Comparison Form the interimental comparison Form the interimental comparison Form to Comparison Form to Improvement Committed	of the plan for falls, the will review the rentions to ensure are dated and imprehensive care in will be in-serviced for of Nursing in of interim care is to comprehensive will review Care in completed plan coordinator to intions are carried in to the plan.	
	100	interventions to pr 483,20(k)(3)(i) SE	event an injury from a fail. RVICES PROVIDED MEET	F:	281	× .	4-27-201

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Event ID: 479Y11

Facility ID; TN3305

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PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(Ve) 14	II TIDI	LE CONSTRUCTION	(X3) DATE S	URVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			COMPLI	
AND ALVI O	CORRECTION		A. BUIL	DING.			
		445380	B. WIN	G		03/3	30/2011
NAME OF B	ROVIDER OR SUPPLIER		<u>-</u> -	STRE	ET ADDRESS, CITY, STATE, ZIP CODI	=	
				579	98 HIXSON HOME PLACE		
LIFE CAR	RE CENTER OF HIXS	SON .		HI	XSON, TN 37343		
(X4) ID PREFIX TAG	VEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y.MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFIGIENCY)	HOULD BE	CX5) COMPLETION DATE
F 281	Continued From pa	age 21	F 2	28,1		48	
	The services provi	ded or arranged by the facility			F 281		
	must meet protess	sional standards of quality.				31	
					Corrective Action:		
	1.5	NT is not met as evidenced					
	by: Based on medical	record review and interview,			The Duragesic patch for R	esident	
	the facility failed to	obtain a prescription refill			#4 was received from the		
	timely for one resid	dent (#4) of seventeen i. For one (#6) of seventeen			pharmacy and placed on the	ie	
	residents, the facil	ity failed to complete pain	M	1	resident on 3/22/11 prior t	o tne	
	assessments per t	protocol; failed to promptly			survey. The resident has a assessment every shift util	izino izino	
	transcribe onto the	Medication Administration or antibiotic treatment, and			the 0-10 pain scale with re	sults	
	failed to document	administration of the antibiotic	10		documented on the Medic	ation	
	medication.				Administration Record.	ranna mari 2005 Denti Delizioni	
	The findings include	ded:				8073	
					The pain assessment for R	esident	1
	Resident #4 was a	admitted to the facility on , with diagnoses including			#6 utilizing the 0-10 pain	scale	3
	Fracture Femur, C	Cerebral Vascular Accident,			was added to the Medicati		
	Osteoporosis and	Mental Disorder.			Administration Record ev	ery sniit	134
	Modical record rev	view of a Physician's order			on 4/1/11.		1
	Hatod Ephruary 17	2011 revealed "Duragesic			Cipro order for Resident #	6 was	
	12 mca/hr (microg	rams/hour) I patch top (topical)			clarified with the physicia	n on	
	q (every) three da	ys"			3/27/11 prior to the survey	and	1.
	Medical record rev	view of a Nurse's note dated			transcribed to the Medical	ion	
	March 21 2011 2	of 2:00 p.m., revealed waiting			Administration Record.		
	for pharmacy fisel	nd Duragesic Patch (pain cg. Order written for patch to be			Urinalysis was repeated for	or this	
	applied up arrival	from pharmacy."			resident on 3/29/11.		
	(A) (A) (A)	iew of the Nurse's note dated			a a	*	
	March 21, 2011, a	at 11:00 p.m., Night shift notified					
	to apply Duragesi	c patch"					
1							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet Page 22 of 3:

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPL	
*1	445380	B. WING			30/2011
NAME OF PROVIDER OR SUPPLIE LIFE CARE CENTER OF HI		5	EET ADDRESS, CITY, STATE, ZIP C 198 HIXSON HOME PLACE IIXSON, TN 37343	CODE ·	* 18
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETION DATE
order dated Mar received the Du Medical record of March 21, 2011 revealed no door symptoms of particles with the 29, 2011 at 10:00 revealed the Physical prescription from medication and delay in receiving Resident #6 was February 15, 200 Chronic Pain Stof nurse's notes "Resident is confused in the confused orders revealed medication) 5 in four hours as in Medical record assessment was February 15, 200 review of the Foundation Additional record 2011 MAR (Medical recor	review of the Pharmacy shipment ch 22, 2011, revealed the facility ragesic patch at 4:09 p.m. review of the Nurse's notes for through March 22, 2011, rementation of any signs or sin. The Director of Nursing on March 20 a.m., in the conference room, narmacy needed a new in the Physician to refill the there was a twenty-four houring the medication. The sadmitted to the facility on 2011, with diagnoses including yndrome. Medical record review and the same share of the pain" The review of current physician's and a current order for Norco (paining-325 mg (milligrams) 1 every seeded for breakthrough pain. The review revealed a paining as completed on the resident on 2011. Continued medical record sebruary and March, 2011, MARS ministration Records) revealed no		Potential: Residents at risk for parapotential to be affected Residents with medical have the potential to be Measures: The Director of Nursing the Pharmacy of the last Prescription for the resident of the Pharmacy of the last Prescription for the resident of the Pharmacy of the last Prescription for the resident of the Pharmacy of the Pharmacy of the Pharmacy of the Will know which preserving the Register weekly so the Will know which preserving the Pharmacy is also faxing Director of Nursing Market of the Physician for significant of the Physician for significant of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy of the Pharmacy	tion orders affected. ag notified pse in sident on ey is now f Nursing a ption at the facility criptions The ag to the fonday — ptions sent gnature that ag or Nursing will reports physician of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION 03/30/2011 B. WING 445380 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5798 HIXSON HOME PLACE HIXSON, TN 37343 LIFE CARE CENTER OF HIXSON PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG DEFICIENCY TAG Every resident April Medication Administration Record was checked by Nursing Administration on 3/31/11 for the presence of a pain assessment every shift utilizing 0-10 scale. The Director of Nursing or Assistant Director of Nursing will perform weekly audits for three months to assess that each resident has a pain scale on the Medication Administration Record and is being documented every shift. Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy and place it in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the on-coming nurse what new orders were If continuation shee

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 1D: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

EPARTMENT OF HEALTH	A LICOLOND CEDVICES				0938-039
ENTERS FOR MEDICARE ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE S	URVEY FIED
) PLAN OF CORRECTION	445380	B. WING		03/3	0/2011
ME OF PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COD	rE ·	
IFE CARE CENTER OF HIXS	ÓИ		IXSON, TN 37343	·	1 2/2
INTI IV	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIC DATE
			received. The on-coming will review the new order notebook and will sign the also checked the order for transcription. This process repeated for the next shift	at they proper s will be	
			three consecutive shifts ar checking the medication of for proper transcription to medication administration	rders the	
<u>.</u>	80		The Director of Nursing pain-service education to the licensed nurses on 4/4/11 included: ordering medicatimely, notifying the Dire Nursing for any unavailable medication, use of the En	that ations ctor of ole	·
			Medication box, the pain to be assessed every shift documented on the medical administration record.	and	
			The Director of Nursing service licensed nurses r medication order transcr process beginning 4/14/	egaroing iption	
			*	1	

FORM APPROVED OMB NO. 0938-0391

DEPART	VICTO TO TABLE	A MEDICAID SERVICES				OIND NO.	
CENTER	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING			Ì
		445380	B. WIN			03/30	/2011
1000	ROVIDER OR SUPPLIER			57	EET ADDRESS, CITY, STATE, ZIP CODE 198 HIXSON HOME PLACE	٠	
LIFE CAR	RE CENTER OF HIXS	SON		н	IXSON, TN 37343		
(X4) ID PREFIX TAG	AND DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	IX.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	COMPLETION DATE
F 281	30, 2011, at 3:02 processing protocol is every shift by documentation the MAR. Interview with the 30, 2011, at 3:05 processing the nurse did not commedication after the pain, the nurse fair antibiotic order; as was not assessed March, 2011 MAR. Medical record resonance on March 17, 201 transferred to the due to a temperate nausea and vomit the 7:00 a.m. to 3 of nurse's notes of nurse's notes of nurse's notes of the facility on March 17, 201 (twice a day) for the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical record resonance of the Medical r	Director of Nursing on March o.m., in the Library, revealed the to assess a resident's pain amenting the level of pain on Director of Nursing on March o.m., in the Library, confirmed document administering pain the resident complained of neck alled to promptly transcribe the and the resident's level of pain levery shift on the February and RS. View of nurse's notes revealed 1, revealed the resident was emergency room at 5:05 p.m., ture of 100 degrees Farenheit, ting, and poor food intake during 1:00 p.m. shift. Continued review revealed the resident returned to rich 18, 2011, at 1:00 a.m., with a for "Cipro (antibiotic) 500 mg tablet) PO (orally) 1 tab BID UTI (urinary tract infection)." eview of the March 2011 nistration Record (MAR) int out) revealed the Cipro order on the MAR, and there was no ne resident received the Cipro		281	An in-service education sess for all licensed nurses is scheduled for 4/27/11 with the pharmacy to review pharmacy/drug ordering produced and education will provided in new hire orients. Licensed nurses will be inserviced on or before 4-27-7. The associates will not be scheduled to work the floor 4-27-2011 until in-service is completed. Director of Nursing, Assistance Director of Nursing or Wee Supervisor will review order checks notebook daily for the months to ensure that the mare completing order checks. Monitor: The Director of Nursing with report results of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescription of the prescriptio	he cess. be ation. 2011. after is ant kend er hree urses is. ill iption reder rmance during three	4-27-2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

PRINTED: U4/U5/ZUTT FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	COMPLET	TED
AND PLAN OF	CORRECTION		B. WING		03/30	/2011
		445380				
	ROVIDER OR SUPPLIER		579	ET ADDRESS, CITY, STATE, ZIP CO 8 HIXSON HOME PLACE	DUE .	×
LIFE CAR	RE CENTER OF HIXS	ON	HIX	(SON, TN 37343		1965
(X4) ID PREFIX TAG	CONTRACTOR DECIDIONE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOULD BE	COMPLETION DATE
5 004	Continued From pa	24	F 281	10		
F 281	(diagnosed) c (with	n) UTI and Cipro ordered O BID. Pt has not been given		: :		2.
¥1	Medical record rev	orders please. Thank you." riew of physician's orders rietion order was obtained on			w 2	
	orally twice a day	Director of Nursing on March	e e			
	the March 2011 M	a.m., in the conference room, ro order was not transcribed to AR until the clarification order		e s		
F 312 SS=D	was obtained on M 483.25(a)(3) ADL	March 27, 2011. CARE PROVIDED FOR	F 312	F 312		
	A resident who is	unable to carry out activities of		Corrective Action:	•	
	maintain good nut and oral hygiene.	intion, grooming, and personal		#1) Resident #7 discu schedule with Director on 3/31/11 and residen	r of Nursing at reported	
	1 TOXIDAN	ENT is not met as evidenced	y :-	that she prefers to sho opposite of her dialysi	wer on days s.	
v	Based on medica	Il record review and interview, o provide showers as requested #7) of seventeen residents		Potential:	0	
	reviewed.			#2) Residents in the f the potential to be affe	acility have	
	The findings inclu			me potomiai to so and		
	40 2000 with dis	admitted to the facility on August agnoses including End Stage		Measures:		
	Renal Disease, I Hypertension.	Diabetes, Diffiditess, and		#3) Director of Nursing shower schedule on 4.	/13/11 to	
	Jacked March 20	eview of the Minimum Data Set 2011, revealed the resident was the interview and required		ensure all residents ar	e included.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11 Facility ID: TN3305

If continuation sheet Page 25 of 3

PRINTED: 04/05/2011 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
HAD E THING OF	·	077.770 5.500.76	1	B. WING		03/30/2011	
		445380	<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	03/3	0/2011
	ROVIDER OR SUPPLIER	ON		57	98 HIXSON HOME PLACE		
LIFE CAN		2.2		н	PROVIDER'S PLAN OF CORRECT	MON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	100.00	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312 F 323 SS=G	for the Month of Fereceived a total of review of the Month 2011, revealed the with the last showed Interview with the right of a.m., in the I did not receive shown of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by the right of the Showered 2-3 tion needed by th	giene. Jiew of the Monthly Flow Report abruary revealed the resident showers. Medical record half Flow Report for the March resident received 2 showers, and the desident on March 14, 2011. Jack Strain of the March 14, 2011. Jack Strain of the resident of the resident of the resident of the resident of the resident of the confirmed the residents are to the sa week and as requested esident. Jack Strain of the March 18, 2011, at the confirmed the residents are to the residents are to the sa week and as requested esident. Jack Strain of the Monthly Flow Report of the residents are to the residents are to the resident. Jack Strain of the March 19, 2011, at the march 19, 2011, at the resident of the residents are to the resident.		312	The Staff Development Coordina serviced nursing staff on 3/30/11 regarding shower schedules to be followed per facility policy. The Director of Nursing in-service nursing staff on 4/4/11 on resider shower schedule. Nursing staff vin-serviced and education will be provided in new hire orientation. Nursing staff will be in-serviced before 4-27-2011. The associate not be scheduled to work the flood 4-27-2011 until in-service is common Showers are to be documented in the charge nurse is to be notified resident refusal of showers and of the refusal on the 24 hour report. Revision of shower schedule as a to accommodate residents needs. The Director of Nursing or Assistant Director of Nursing print and review RITA documentation twice weekly three months to ensure residence receiving showers as scheduled.	ced at vill be on or s will or after apleted, a RITA. d of any locument meeded /wishes. ang will	
		×			Monitor:		
	by: Based on medical interview, the facili interventions to pre-	record review, observation and ty failed to implement event an injury from a right elbow resulting in harm to enteen residents reviewed.			#4) The Director of Nursing report findings of RITA documentation review regardshowers to Performance Improvement Committee d	rding	
	resident #4 of sevi				monthly meeting for three months.		4-27-2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet Page 26 of 35

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

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F 323 Continued From page 26 The findings included: Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur. Cerebral Vascular Accident, Osteoporosis and Mental Disorder. Medical record review of the Physician Recapitulation Orders dated February 17, 2011, revealed "NWB RLE[non weight bearing Right dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed. Medical record review of the Interim Care Plan dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed. Medical record review of the Interim Care Plan dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed. Medical record review of a Nurse's note date February 26, 2011, revealed "Pt (patient) found on knees upon entering room by staff. Bed alarm ringing. Jobh knees is (slightly) red, no open areas noted. No c/o (complaints) of palm Medical record review of the fall investigation dated February 26, 2011, revealed "Resident demonstrated use of call light. Discontinue TED (anti-embolism hose) nose" Medical record review of a Nurse's note date February 27, 2011, revealed "Resident demonstrated use of call light. Discontinue TED (anti-embolism hose) nose" Medical record review of a Nurse's note dated February 27, 2011, revealed "Resident demonstrated use of call light. Discontinue TED hose which would prevent her from sliding on the floor due to the slick material of the TED hose. The second fall was on 2/2/7/11 and a scoop (bolster-sided) mattress and parameter mats to bedside were	LIFE CAF	RE CENTER OF HIXS	ON				
The findings included: Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis and Mental Disorder. Medical record review of the Physician Recapitulation Orders dated February 17, 2011 revealed "NWB RLE (non weight bearing Right Lower Extremity)" Medical record review of a Fall Risk Assessment dated February 17, 2011, revealed the resident was high risk for falls. Medical record review of the Interim Care Plan dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed. Medical record review of a Nurse's note date February 26, 2011, revealed "Pt (patient) found on knees upon entering room by staff. Bed alarm ringingboth knees is (slightly) red, no open areas noted. No c/o (complaints) of path" Medical record review of the fall investigation dated February 26, 2011, revealed "Resident demonstrated use of call light. Discontinue TED (anti-embolism hose) hose" Medical record review of a Nurse's note dated February 27, 2011, at 5:20 a.m. revealed "Resident found on the floor bybed '! thought! was at home'does co/(complain of) it (right) Medical record review of a Nurse's note dated February 27, 2011, at 5:20 a.m. revealed "Resident found on the floor bybed '! thought! was at home'does co/(complain of) it (right) Medical record review of a Nurse's note dated February 27, 2011, at 5:20 a.m. revealed "Resident found on the floor bybed '! thought! was at home'does co/(complain of) it (right) Resident #4 was assessed for fall risk upon admission and currently has the following interventions in place to help reduce falls: she is on Physical and Occupational Therapy caseloads, she utilizes a low bed with parameter mats, scoop (bolster-sided) mattress with blanket roil, call-light in reach, nonskid footwear and she is on the falling star program. Resident has had three falls since admission. The first fall was 2/26/11, the new interven	(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETIC	
Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis and Mental Disorder. Medical record review of the Physician Recapitulation Orders dated February 17, 2011 revealed "NWB RLE (non weight bearing Right Lower Extremity)" Medical record review of a Fall Risk Assessment dated February 17, 2011, revealed the resident was high risk for falls. Medical record review of the Interim Care Plan dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed. Medical record review of a Nurse's note date February 26, 2011, revealed "Pt (patient) found on knees upon entering room by staff. Bed alarm ringingboth knees si (slightly) red, no open areas noted. No c/o (complaints) of pain" Medical record review of the fall investigation dated February 26, 2011, revealed "Resident demonstrated use of call light. Discontinue TED (anti-embolism hose) hose" Medical record review of a Nurse's note date February 27, 2011, at 5:20 a.m. revealed "Resident found on the floor bybed 'I thought! was at home,"does c/o(complain of) rt (right) to sea so the ded were	F 323	The findings includ	ed:	F 32	F 323		
		February 17, 2011 Fracture Femur, C Osteoporosis and Medical record rev Recapitulation Ord revealed "NWB I Lower Extremity) Medical record rev dated February 17 was high risk for fa Medical record rev dated February 17 implemented a lov alarm to the bed. Medical record rev February 26, 2011 on knees upon en ringingboth knee areas noted. No c Medical record rev dated February 26 demonstrated use (anti-embolism ho Medical record rev february 27, 2011 "Resident found of was at home"do	with diagnoses including erebral Vascular Accident, Mental Disorder. iew of the Physician iers dated February 17, 2011 RLE(non weight bearing Right iew of a Fall Risk Assessment iew of the Interim Care Plan iew of the Interim Care Plan iew of the Interim Care Plan iew of the Interim Care Plan iew of the Interim Care Plan iew of a Nurse's note date iew of a Nurse's note date iew of a Nurse's note date iew of a Rightly) red, no open iew of the fall investigation iew of a Nurse's note dated iew of a Nurse's note dated in the floor bybed I I thought I es c/o(complain of) rt (right)		Resident #4 was assessed for risk upon admission and cur has the following intervention place to help reduce falls: shon Physical and Occupations. Therapy caseloads, she utilized low bed with parameter mat scoop (bolster-sided) mattre with blanket roll, call-light is reach, nonskid footwear and on the falling star program. Resident has had three falls admission. The first fall was 2/26/11, the new intervention implemented post-fall were education to utilize the callfor assistance, for which resexpressed understanding. Resident also discontinued hose which would prevent the from sliding on the floor duthe slick material of the TEL hose. The second fall was a 2/27/11 and a scoop (bolster sided) mattress and parameters.	rently ons in he is al zes a s, ss n he she is since s ns re- light hident TED her e to D on r-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet Page 27 of 35

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

EPARTMENT OF HEALTH	- HERIONIO CEDVICES			OMB NO. 0930-039
ENTERS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
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<u> </u>	445380	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
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IFE CARE CENTER OF HIXS	ÒИ	Н	IXSON, TN 37343	
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			implemented. The third fa on 3/12/11 and the new intervention was to add a roll to scoop (bolster-side mattress. She has been fro falls since 3/12/11.	blanket i)
			Residents at risk for falls potential to be affected. Measures: Residents are assessed for upon admission, after each with each significant characteristic and quarterly with Minimum Data Set assess Interventions are implemeach resident according to	r fall risk th fall, the in the the the the the the the the the the
			individual need.	
	6 6 8 8 0			continuation shee .27 A

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

OCKITEDO	FOR MEDICARE	& MEDICAID SERVICES				, 0000 0001	
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ND PLAN OF C	ORRECTION	DEM LIFICATION NUMBER.	A. BUIL	DING	- .		
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				5798 HIXSON HOME PLACE		•	
LIFE CARE	CENTER OF HIXS	ON .		HIXSON, TN 37343		045	
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F 323 C Md de b	Medical record revelow stat (immedical record revelow stat (immedical record revelow) Medical record revelow (elbow) Medical	iew of the Physician's order, 2011, revealed "x-ray of rt iately). Fall pads to floor around view of the x-ray report dated, revealed "Slightly distracted fracture" iew of the fall investigation, 2011, revealed the facility pop mattress and mats to the dent's return to the facility. view of a Nurse's note dated vealed "pt (patient) NPO (after) midnightDue to "view of a Nurse's note dated evealed the resident "returned et) after surgery" arch 30, 2011, at 10:45 a.m, ent in bed with pressure alarm attress with bolsters to the bed	F3	Charge nurses implereduction intervention. The weekend supervon call are additional that the nurse may uneeded for questions after hours. We also interventions on the the C.N.A.'s. IDT follows up on falls I through Friday during event meeting. Residents are discuss Interdisciplinary Tefall and care planned are reviewed and reneeded.	ement new fall ons post fall. visor and nurse il resources tilize as s and concerns o put fall care guide for reviews and Monday ng clinical essed by the am after each d interventions	4-27-2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

DEPARIM	FMI OF HEVELL	THE THE ALD OF DIVICES	18		ONIO ITO.	
CENTERS	FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SU	RVEY
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A BUILD		COMITCE	
AND I DATE			B. WING	·	03/30	0/2011
		445380		TREET ADDRESS, CITY, STATE, ZIP (CODE	
NAME OF PRO	VIDER OR SUPPLIER		ľ	5798 HIXSON HOME PLACE	4 8	
LIFE CARE	CENTER OF HIXS	бÓИ		HIXSON, TN 37343		750
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE ()	COMPLETION DATE
			+	The Director of Nursing	g provided	
,	*			in-service education to	nursing	
1,			1	staff on 4/4/11 to review	v falls	
-				management, fall risk a	ssessment,	
			1	falling star program, ris	k factors	
				for falls, additional inte	erventions	
				and approaches to decr	ease the	1
			1	risk of falls and investi	gation of a	
			1	resident fall. Licensed	Nurses .	
	1.5			will be in-serviced and	education	
1.				will be provided in nev	v hire	
			ļ	orientation. Licensed l	Nurses Will	
			1	be in-serviced on or be	tore 4-2/-	,
1 1		19		2011. The associates v	vill not be	
			* 4	scheduled to work the	Hoor aner	
				4-27-2011 until in-serv	vice is	ì
				completed. Fall interv	ention	
1			1	devices are kept in sup	ppy room	1.
	•			where the charge nurse. The Director of Nurse.	e or	1
87.				Assistant Director of	Viirses	
				reviews the Incident F	ollow-up	
				and Recommendation	Form to	
	71			and Recommendation	entions were	
		3		implemented and effe	ctive after a	
				fall.		
				1001.		
			1 .	Monitor:		1.
				The Director of Nurse	es discusses	
		*		falls and trends with	the	
		£ 71	,	Interdisciplinary Tear	n in the	
		ž		monthly Performance	;	
1		a 9		Improvement Meetin	.g	1
1				5-60v ID: TN3305	If continuation she	€28A

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	_		(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING	COMPLET	TED
		445380	B, WING	G	03/30)/201 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 5798 HIXSON HOME PLACE	DE	t).
LIFE CAF	RE CENTER OF HIXS	ON.		HIXSON, TN 37343		
(X4) ID PREFIX TAG	TENOU DEEKSENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 332	resulting in harm.	required surgical repair OF MEDICATION ERROR	F 3	F 332 Corrective Action:		1,
	The facility must en medication error rather than the medication error rather than the medications were residents (#16, #1, observed on medication error rather findings included than the medication on Might Licensed Prant 100 hall, revealed	insure that it is free of otes of five percent or greater. INT is not met as evidenced tion, medical record review, facility failed to ensure administered correctly for three 5, #9) of twelve residents cation pass resulting in a ate of 8%. Ided: arch 29, 2011, at 9:15 a.m., ctical Nurse (LPN #1), on the five following medication errors:		#1) Unable to complete corrective action for residuhor received 325mg of fisulfate. He showed no sisymptoms of adverse efficienceiving 325mg of ferror instead of 300mg ferrors. LPN #1 administered and 20mg of lasix to resident March 29, 2011 so that he dose received was 40mg ordered. Resident #15 was given 10 units of Novolog Institution.	gns or ect due to us sulfate sulfate. other #16 on is total as	>
	LPN #1 administemg. (milligrams) to Review of the phy 2011, revealed, "p.o. (by mouth)" LPN #1 administe #16. Review of the phy 2011, revealed, "a.m" Interview with LPI or many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a many and the 100 has a ma	red fron (Ferrous Suitate) \$25		3/29/11 by LPN #2 is an equal the 20 units ordere physician. Corrective action for res who had received omept 20mg by LPN#3 after ea breakfast, physician order changed on 3/30/11 to regiving omeprazole prior breakfast.	RN to d by the ident #9 fazole ting er was effect	

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Event ID: 479Y11

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PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SI COMPLE	
	ROVIDER OR SUPPLIER		57	ET ADDRESS, CITY, STATE, ZIP COL 98 HIXSON HOME PLACE XSON, TN 37343	DE	8
(X4) ID PREFIX TAG	VENCH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A PREFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 332	2011, at 5:30 p.m., revealed LPN #2 a 10 units to Resider physician's orders Novolog Insulin 20 400 and notify the Interview with LPN p.m., at the 100 haunits of Novolog In of 20 units. Contin physician had been sugar over 400 and return phone call fit Resident #9 was a October 12, 2007, Schizophrenia, Hy Medical record reversity Recapitulation ord 2011, revealed " Medication) 20 mg daily. Observation on Meduring the medical Practical Nurse (LOmeprazole 20.m.	nedication pass on March 29, with LPN #2, on the 100 hall, administered Novolog Insulin ht #15. Review of the dated March 2011, revealed units for blood sugars above Medical Doctor. #2 on March 29, 2011, at 6:30 all nursing station confirmed 10 asulin was administered instead nued interview confirmed the notified of an elevated blood of LPN #2 had not received a from the physician. Idmitted to the facility on with diagnoses including pertension, Difficulty Walking. Priew of the Physician ers for the month of March of Castric Reflux of the per mouth twice arch 29, 2011, at 8:15 a.m., tion pass revealed Licensed PN) #3 administered g by mouth.	F 332	Potential: #2) Residents receiving medications have the pot be affected. Measure: #3) Director of Nursing is serviced licensed nursing 4/4/11 regarding five right medication administration. Licensed nurses will be in serviced and education we provided in new hire orient Licensed nurses will be inserviced on or before 4-2. The associates will not be scheduled to work the floury 4-27-2011 until in-serviced completed. Director of Nursing proves on-one education with LI LPN #2 is an RN and LP regarding medication administration to include rights of medication administration on 4/13/11	staff on ats of a	
	10:30 a m. confir	N #3 on March 29, 2011, at med the resident had eaten the administration of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second			2	

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Event ID: 479Y11

Facility ID: TN3305

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PRINTED: 04/05/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING AND PLAN OF CORRECTION B. WING 03/30/2011 445380 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5798 HIXSON HOME PLACE HIXSON, TN 37343 LIFE CARE CENTER OF HIXSON PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Nursing Administration or Pharmacy Staff will conduct medication pass observations with medication nurses weekly for three months beginning 4/13/11. Monitor: Director of Nursing will report results of medication pass observations to the Performance Improvement Committee during monthly Performance Meeting for three months.

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Event 10: 479Y11

Facility ID: TN3305

If continuation shee 30 A

PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	e constitue iiei	(X3) DATE SURVEY COMPLETED	
2		445380	B. WING		03/30/2011
	ROVIDER OR SUPPLIER		579	ET ADDRESS, CITY, STATE, ZIP CODE 98 HIXSON HOME PLACE XSON, TN 37343	
LIFE CAR				PROMPER'S PLAN OF CORRECTION	BE COMPLETION
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F 332	Continued From p	page 30	F 332		
79 4 00	Review of the pact be taken before e	kage insert revealed " should aling"			10
F 333	2011, at 2:15, in t Omeprazole is to 483.25(m)(2) RES	Corporate Nurse on March 30, he conference room, confirmed be given before meals. SIDENTS FREE OF	F. 333	£	4-27-2011
SS=D	- COLUMN ANT BAS	ED ERRORS		9	
	The facility must any significant me	ensure that residents are free of edication errors.		· .	
	2		ž.	F 333	
	This REQUIREM	ENT is not met as evidenced.	1	3	
	by:	I record review and interview,		Corrective Action:	
	the facility failed t	o ensure one (#6) of seventeen s was free of a significant	15	Cipro order for Resident #6 w	as
	medication error.	5 HG5 HG5 HG5		clarified with the physician or	ı i
				3/27/11 prior to the survey.	
	The findings inclu	ideo.		Urinalysis was repeated for th	18
	Echeusey 15 201	admitted to the facility on 1, with diagnoses including		resident on 3/29/11.	
	Chronic Pain Syr Failure and Chro	ndrome, Congestive Heart nic Obstructive Pulmonary		Potential:	2
1	Disease.			Residents with medication or	ders
	on March 17 20	eview of nurse's notes revealed 11, the resident was transferred		have the potential to be affect	ed.
	to the emergence	v room at 5:05 p.m., due to a]		
	duamiting of	00 degrees Farenheit, nausea of poor food intake during the			
	7.00 to 3.00	Jum sult Collinary Leview S.			*
	la motor ro	vealed the resident returned to arch 18, 2011, at 1:00 a.m., with a			ation sheet Page 31 of

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Event ID: 479Y11

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CENTERS FOR MEDICARE & MEDICADO SERVICES (XI) PROVIDER VALUE OF PROVIDER VALUE OF PROVIDER VALUE OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF PROVIDER OF P	DEFAILI	VICTO OF THE PER	MEDICAID SERVICES	755 — 1014 <u>— 10</u> 44		1	0950 0551
INDEPLATION CORRECTION 445380 STREET ADDRESS, CITY, STATE JP CODE STREET ADDRESS, CITY, STATE JP CODE STREET ADDRESS PLAN OF CORRECTION GRAPH OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (BACH DEPROVIDER PLAN OF CORRECTION GRAPH OF CORRECTIVE ACTION SHOULD BE PROVIDED PROVIDER PLAN OF CORRECTION GRAPH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFOULTORY OR LSC IDENTIFYING INFORMATION) Measures: Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the on- coming nurse what new orders were received. The on-coming nurse will review the new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication orders for proper transcription to the medication administration record. The Director of Nursing will in- service licensed nurses regarding medication order transcription process beginning 4/13/11.	CENTERS	S FOR MEDICARE	LIVIN PROVIDERISHPPLIERICHA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			JRVEY TED
NAME OF PROMODER OR SUPPLIER LIFE CARE CENTER OF HIXSON STREET ADDRESS, CITY, STATE, ZIP CODE STRIP HIXSON TO STATEMENT OF DETRICIDENCIES HIXSON, TN 37343 SUMMARY STATEMENT OF DETRICIDENCIES HOW FULL REGULATION OR LIST DETRICIPATION OF DETRICIDENCIES HOW FULL REGULATION OR LIST DETRICIPATION OR LIST DETRICATION OR	STATEMENT (AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	·	QQIIII EE	
LIFE CARE CENTER OF HIXSON SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGE			445380				0/2011
OC.) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG.) PREFIX TAG. Measures: Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the oncoming nurse will review the new orders were received. The on-coming nurse will review the new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication order transcription to the medication administration record. The Director of Nursing will inservice licensed nurses regarding medication order transcription. The foreign and the feedback of the process beginning 4/13/11.				5	798 HIXSON HOME PLACE	DE .	
PREFIX TAGE REGULATORY OR ISC IDENTIFYING BYTORMATION) PREFIX TAGE REGULATORY OR ISC IDENTIFYING BYTORMATION) PREFIX TAGE REGULATORY OR ISC IDENTIFYING BYTORMATION) Measures: Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the oncoming nurse what new orders were received. The on-coming nurse will review the new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication orders for proper transcription to the medication administration record. The Director of Nursing will inservice licensed nurses regarding medication order transcription process beginning 4/1311.	LIFE CAR	E CENTER OF HIXS	ÇÔN .	Н			_ ~c
Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the oncoming nurse what new orders were received. The on-coming nurse what new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication orders for proper transcription to the medication administration record. The Director of Nursing will inservice licensed nurses regarding medication order transcription process beginning 4/13/11.	PREFIX		A MUICE BE DEFCEDED BY LOT	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	
Event ID: 479Y11 Facility ID: TN3305 If continuation shee	TAG				Medication orders are to to the pharmacy. After homore is to call the pharmatell them that they are far new order. The nurse is the medication order fax confirmation copy in the checks notebook. The misign off that this medicate was transcribed to the Madministration Record. Shift change report, the conting nurse will report off with coming nurse what new were received. The oncoming nurse will review the new in the notebook and will they also checked the or proper transcription. The will be repeated for the so that three consecutive checking the medication for proper transcription medication administration. The Director of Nursing service licensed nurses medication order transcription or medication order transcription or medication order transcription or medication order transcription or medication order transcription or transc	ours, the acy and king a to place order urse is to ion order edication During off-going a the on-orders coming worders sign that der for his process next shift, e shifts are a orders to the on record.	
		<u> </u>	Event ID: 47	9Y11	Facility ID: TN3305	f continuation she	е

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Event ID: 479Y11

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CENTERS FOR MEDICARE & MEDICAID SERVICES		& WEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY	
STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	E1E0	
		445380	B. WING		03/3	0/2011	
	ROVIDER OR SUPPLIER		57	EET ADDRESS, CITY, STATE, ZIP CO 198 HIXSON HOME PLACE IXSON, TN 37343)DE		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	IĎ PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 371 SS=F	physician's order from (milligrams) tab (take) (twice a day) for U Medical record revealed there was resident received to Medical record revealed a "Fax O noted as "priority" a.m. Continued received (diagnosed) c (with 3/18/11 500 mg P Cipro. Need new Medical record revealed a clarific March 27, 2011, a orally twice a day Interview with the 29, 2011, at 10:45 confirmed the residnation of the residuals. 483.35(i) FOOD F STORE/PREPAR The facility mustations and the residuals are the residuals and the residuals and the residuals.	or "Cipro (antibiotic) 500 mg ablet) PO (orally) 1 tab BID TI (urinary tract infection)." riew of the March 2011 stration Record (MAR) s no documentation the the Cipro until March 27, 2011. riew of physician's orders rder Request/Noification Form", on March 27, 2011, at 7:55 eview of the "Fax Order led "Pt. (patient) was Dx h) UTI and Cipro ordered O BID. Pt has not been given orders please. Thank you." view of physician's orders ation order was obtained on at 3:11 p.m., for Cipro 500 mg 1 "till all gone". Director of Nursing on March is a.m., in the conference room, ident did not receive the ed by the physician for nine PROCURE, E/SERVE - SANITARY from sources approved or actory by Federal, State or local and distribute and serve food	F 333	Director of Nursing, A Director of Nursing or Supervisor will review checks notebook daily months to ensure that the are completing order of Monitor: The Director of Nursin report results of order checks to the Performat Improvement Commit the monthly Performat Improvement Meeting months.	Weekend order for three the nurses hecks. In will review ance tee during nce	4-27-2011	
		g		10		***	
		(a)				1	
	1	Event ID: 479Y1	11 Fa	acility ID: TN3305	If continuation shee	et Page 32 of 3	

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Event ID: 479Y11

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-1				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445380	B. WIN	G		03/3	0/2011
	ROVIDER OR SUPPLIER	SON		57	EET ADDRESS, CITY, STATE, ZIP COI 198 HIXSON HOME PLACE IXSON, TN 37343	DE .	
			1				T
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 371			F3	371	F 371		
٠	bv:	NT is not met as evidenced			Corrective Action:		
	Based on observation and interview, the facility failed to maintain the dietary department in a clean and sanitary manner.		٠		Pans in the dietary department washed and air-dried on 3/28	3/11.	
	The findings included:				The food was properly stored freezer and the cooler on 3/2	8/11.	
s .	the dietary department of the serving partment of the partment of the dietary department of the partment of th	used for the tray line, were particles of food stuck inside ans, used for the tray line were			The leftovers were discarded The carbon build-ups on two cleaned on 3/28/11. Unable to complete corrective the thermometer wiped with towel. Dietary staff was in-s 4-13-2011, proper sanitation used during food temperature process.	pans were re action for a paper erviced on techniques	
	2011, at 11:15 a.m hamburger patties enclosed plastic binot closed. Contifreezer revealed to pork roast, placed open to the air. Observation of the March 28, 2011, a Certified Dietary Mithermometer into the thermometer and towel, between us food.	walk-in freezer on March 28, i., revealed one box of 8 - 10 which was opened and the ag containing the patties was nued observation of the walk-in wo small cooked portions of on the shelf, unwrapped and tray line food temperatures, on talifold 11:53 a.m., revealed the lanager placed the wiped it with a brown paper e for nine different types of			Potential: Residents in the facility have potential to be affected. Measures: The Regional Director of Cli Services provided 1:1 educated Certified Dietary Manager reproper sanitation techniques the food temperature process.	inical tion to the egarding the used during	
	March 28, 2011, a	Certified Dietary Manager on t 12:30 p.m., in the kitchen, ving pans were stacked arbon build up; the freezer had	•				

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Event ID: 479Y11

Facility ID: YN3305

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E & MEDICAID SERVICES	7000 100 500	DI E CONSTRUCTION	(X3) DATE S	URVEY	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1200000	A BUILDING		COMPLETED	
445380	B. WING _			0/2011	
l.	5	798 HIXSON HOME PLACE	CODE		
~V MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
		by the Certified Dietary I proper cleaning and stora proper food storage incluand the proper sanitation during the food temperat process. Dietary staff wi on or before 4-27-2011. will not be scheduled to after 4-27-2011 until inscompleted. Upon new-hire orientatic Dietary Manager inserv on the proper cleaning a pans, proper food storag leftovers, and the proper techniques used during the temperature check proces. The Certified Dietary Manager inserved the proper techniques used during the temperature check proces.	Manager on ge of pans, ding leftovers, techniques used are check ll be in-serviced. The associates work the floor service is on, the Certified ices dietary staff and storage of e including sanitation he food ss.		
		weekly to include an ope checklist. The Registered Dietician inspects the dietary department and provides the Execut	ening and closing n randomly ntment monthly ive Director and	4-27-20	
- × ×		report the findings of the monthly dietary inspecti Performance Improvem during the monthly Perf	e weekly and ons to the ent Committee formance e Meeting		
	500028	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445380 A BUILDIN B. WING STR SON	(X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP 5798 HIXSON, TN 37343 PROVIDER'S PLAN OF 1 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE Dietary staff was in-servi by the Certified Dietary M proper cleaning and stora proper food storage inclu and the proper sanitation during the food temperat process. Dietary staff will on or before 4-27-2011 until in-s completed. Upon new-hire orientatic Dietary Manager in-serv on the proper cleaning a pans, proper food storage leftovers, and the proper techniques used during to temperature check proce The Certified Dietary M completed department in weekly to include an ope checklist. The Registered Dietician inspects the dietary depa and provides the Execut the Certified Dietary M written report. Monitoring: The Certified Dietary M report the findings of the monthly dietary inspect Performance Improvement Committe monthly for three month	(X3) MULTIPLE CONSTRUCTION A BUILDING SON STREET ADDRESS, CITY, STATE, ZIP CODE 5738 HIXSON HOME PLACE HIXSON, TN 37343 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SKOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY LISC IDENTIFYING INFORMATION) Dictary staff was in-serviced on 4/13/11 by the Certified Dietary Manager on proper cleaning and storage of pans, proper food storage including leftovers, and the proper sanitation techniques used during the food temperature check process. Dietary staff will be in-serviced on or before 4-27-2011 until in-service is completed. Upon new-hire orientation, the Certified Dietary Manager in-services dietary staff on the proper food storage of pans, proper food storage of pans, proper food storage of pans, proper food storage including leftovers, and the proper sanitation techniques used during the food temperature check process. The Certified Dietary Manager completed department inspections weekly to include an opening and closing checklist. The Registered Dietician randomly inspects the dietary department monthly and provides the Executive Director and the Certified Dietary Manager with a written report. Monitoring: The Certified Dietary Manager with a written report. Monitoring: The Certified Dietary Manager with a written report. Monitoring: The Certified Dietary Manager with a written report. Monitoring:	

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PRINTED: 04/05/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(YOU MILL	I TIOI I	E CONSTRUCTION	(X3) DATE SU	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLET	TED
	¥	445380	B. WING			03/30	/2011
	ROVIDER OR SUPPLIER			579	ET ADDRESS, CITY, STATE, ZIP CODE 8 HIXSON HOME PLACE		¥
LIFE CA	RE CENTER OF HIXS	SON.		HIX	(SON, TN 37343	7700	
(X4) ID PREFIX TAG	ALVER DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 371	Continued From pa	age 33	. F.3	71	· ·		
	hamburger patties	and the pork roast were left d the thermometers were			F 372		
	temperatures	er towel after taking the food			Corrective Action:		
F 372 SS=F	483.35(i)(3) DISPO PROPERLY	OSE GARBAGE & REFUSE	F3	3/2	Dumpster and area was cleaned of 3/28/11.	n	
	The facility must d properly.	ispose of garbage and refuse			Potential:		,
(4)		NT is not met as evidenced			Residents in the facility have the potential to be affected.		
*	by: Based on observa	tion and interview, the facility he dumpster area in a			Measure:		
*	clean/sanitary mar	nner.			Facility has added additional was refuse pick up to ensure sanitary	te	
	the dumnster area	arch 28, 2011, at 11:45 a.m., of revealed the facility had two			Dumpster environment on April 1		
	dumpeters one fo	r the card board boxes and one ntinued review revealed the two			The Certified Dietary Manager at Dietary Staff perform a Dumpster	nd.	
	doors on the dum	pster, used for trash, were left parbage bags were left opened			inspection daily and complete a c sheet.	heck	
	inside the dumpst split open allowing track of the door a	er and one bag at the door was ng liquids to spill out into the and around the opening. ation revealed the dumpster ardboard boxes was			Maintenance pressure washes the Dumpster and surrounding area vand maintains a log.	e weekly	
	overflowing, with I	one side of the top open to the			Monitor:		
	rain. Continued of	bservation revealed a large sh cart used to transport trash to behind the dumpsters, and was			The Certified Dietary Manager v provide a summary of results of inspections to the Performance	dumpster	
	Interview with the	Certified Dietary Manager on at 12:30 p.m., at the dumpster he dumpsters were over filled,			Improvement Committee During monthly Performance Improvem Meeting monthly for three montensure compliance.	ent	4-27-20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED		
22		445380	B. WING_		<u> </u>	03/30/2011	
	ROVIDER OR SUPPLIER	SON		REET ADDRESS, CITY, STA 1798 HIXSON HOME PLAC HIXSON, TN 37343			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		/E ACTION SHOULD BE D YO THE APPROPRIATE	(X5) COMPLETION DATE		
F 372	opened, with bags	top of one dumpster left of gargage opened. w confirmed the area around re cluttered and not left in a	F 372				
E	800	4			1000		
E	(*)	*			1,		
		,		,			
		ne Obsolete Event ID: 479Y	71 F	Facility ID: TN3305	If continuation shee	t Page 35 of 3	

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